

Today's Date: _____

ARE YOU CURRENTLY A RESIDENT IN A SKILLED NURSING FACILITY? YES NO NAME: _____

Patient Account#

Mr. Miss Mrs. Ms. Male Female Family MD/PCP: _____

First Name MI Last Name Preferred Name

Marital Status: Single Married Divorced
 Legally separated Widowed

Street Address City State/ZIP

SSN# Date of Birth Home Phone Ph# where best can be reached during the day ext. Cell Phone

Email Address Employer Occupation

Guardian or Nursing Home

Emergency Contact (relationship To Patient) Phone # Person Responsible for Account

How were you originally referred to our office?

Phone Book School Advertisement Patient _____
 Insurance Listing Drive by Website Doctor _____
 Self Referral Other _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State/ZIP

M F

Insured's First Name MI Insured's Last Name Insured's Date of Birth

Insured's Work Status:
 F/T P/T Retired/Date: _____

Insured's Policy/ID# Group Number Insured's Employer

Patient Relationship to Insured Patient Status:
 Self Spouse Child Other F/T student P/T Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State/ZIP

M F

Insured's First Name MI Insured's Last Name Insured's Date of Birth

Insured's Work Status:
 F/T P/T Retired/Date: _____

Insured's Policy/ID# Group Number Insured's Employer

Patient Relationship to Insured Patient Status:
 Self Spouse Child Other F/T student P/T Student Employed

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process all claims, including deductible and benefit status for medical and private insurance companies.

x PATIENT SIGNATURE: _____ Date: _____

I authorize the release of direct payment for medical benefits to my physician.

x PATIENT SIGNATURE: _____ Date: _____

I understand that I will be financially responsible for all non-covered services or services denied for medical necessity.

x PATIENT SIGNATURE: _____ Date: _____

WE WILL NEED A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE/ID

Name **PATIENT MEDICAL HISTORY/INFORMATION**
PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician _____ City _____ State _____ Zip _____ Phone _____

PHARMACY

Pharmacy Name _____ Pharmacy Phone# _____

PERSONAL HEALTH HISTORY

What is the main reason for today's exam ? _____
 When was your last eye exam ? _____ When was your last health exam ? _____

Drug Allergies (Medicines that cause reactions or sensitivities): _____

Other Allergies: _____

Serious Illnesses or Injuries: _____

Past Surgeries (include date): _____

Eye Surgeries (include date): _____

Current Medications: _____
 (include reason why taking) _____

Current Eye Drops: _____

Are you diabetic? Yes No Type I or Type 2? _____

If yes, how old were you when diagnosed? _____

Controlled w/ diet, pills, or insulin? _____

Name of doctor who manages your diabetes? _____

YOUR EYE HISTORY

Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Dryness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No
Cataract	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing/Watering	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision @ Distance	<input type="radio"/> Yes <input type="radio"/> No
IOL lens implant	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision @ Near	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye or Lid	<input type="radio"/> Yes <input type="radio"/> No	Double Vision	<input type="radio"/> Yes <input type="radio"/> No
Headaches	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No	Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	Drooping Eyelid	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Redness	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No	Color Blindness	<input type="radio"/> Yes <input type="radio"/> No

YOUR CURRENT GENERAL HEALTH CONDITION

Fever	<input type="radio"/> Yes <input type="radio"/> No	Heart Problems	<input type="radio"/> Yes <input type="radio"/> No	Anxiety or Depression	<input type="radio"/> Yes <input type="radio"/> No
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Respiratory (Asthma)	<input type="radio"/> Yes <input type="radio"/> No	Thyroid problems	<input type="radio"/> Yes <input type="radio"/> No
Other Symptoms	<input type="radio"/> Yes <input type="radio"/> No	Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	Blood/Lymph	<input type="radio"/> Yes <input type="radio"/> No
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No	Kidney	<input type="radio"/> Yes <input type="radio"/> No	Allergies	<input type="radio"/> Yes <input type="radio"/> No
High Blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Muscles, Bones, Joints	<input type="radio"/> Yes <input type="radio"/> No	Are you pregnant?	<input type="radio"/> Yes <input type="radio"/> No
		Skin problems	<input type="radio"/> Yes <input type="radio"/> No	Are you nursing?	<input type="radio"/> Yes <input type="radio"/> No
		Neurological (weakness, tingling, numbness)	<input type="radio"/> Yes <input type="radio"/> No		

FAMILY HISTORY (immediate family such as parents, grandparents, siblings) not you.

Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Cataract (s)	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No		

SOCIAL HISTORY/ CONTACT LENS QUESTIONNAIRE

Name _____

SOCIAL HISTORY

Current Occupation: _____ Years _____ Employer _____

Do you live with: (***Please circle***) alone, w/ spouse, w/ family, or nursing home/assisted living center

Do you smoke ? If yes, how much/often : No Occasional 1/2 pack/day 1 pack/day 1+ pack

Do you drink alcohol ? If yes, how much/often : No Occasional 1 Per Day 2-3/day 4+/day

Method of Tobacco Intake : Smoking Chewing

Do you use Illegal drugs? Yes No

Do you engage in regular exercise? Yes No

Do you use nutritional supplements (vitamins etc.)? Yes No

Hobbies/ Interests : _____

SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, special anti-glare tints or coatings)
- Occupational (mechanics, plumbers, pilots)
- Safety Glasses (gardening, woodworking, welding)
- Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Do you currently wear contact lenses? Yes No Since: - _____

_____ Type (soft or hard) and brand of contact lenses _____

How many hours/day ? _____

How many days/week ? _____

Today's wearing time ? _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? Yes No

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

HIPAA INFORMATION

HIPAA Policy Received/ signed? Signed: